CHIA.
center for health information and analysis

Massachusetts All Payer Claims Database (MA APCD)

Release 4.0, Documentation Guide

Government User Documentation

CY 2010-2014

Center for Health Information and Analysis

Document Revision History

Date	Version Number	Changed/Created by	Requested by:	Change:
October 2015	1.0	Kathryn Scribner	Kevin Walsh	First Draft

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INTRODUCTION

The Center for Health Information and Analysis (CHIA) was created to be the hub for high quality data and analysis for the systematic improvement of health care access and delivery in Massachusetts. Acting as the repository of health care data in Massachusetts, CHIA works to provide meaningful data and analysis for those seeking to improve health care quality, affordability, access, and outcomes.

To this end, the Massachusetts All Payer Claims Database (MA APCD) contributes to a deeper understanding of the Massachusetts health care delivery system by providing access to accurate and detailed claims-level data essential to improving quality, reducing costs, and promoting transparency. This document provides the user with information on Release 4.0 of the MA APCD.

Overview

MA APCD data is comprised of medical, pharmacy, and dental claims and information from the member eligibility, provider, product and benefit plan files, that are collected from health insurance payers operating in the Commonwealth of Massachusetts. This information encompasses public and private payers as well as insured and self-insured plans. This release also introduces MassHealth Medicaid data to the APCD for the period of calendar years 2012-2014.

MA APCD data collection and data release are governed by regulations. These regulations are available on the MA APCD website. (See http://chiamass.gov/regulations/.)

For ease of use, the Center for Health Information and Analysis (CHIA) has created separate chapters for each APCD file type:

- Dental Claims (DC),
- Medical Claims (MC),
- Pharmacy Claims (PC),
- Member Eligibility (ME),
- Product File (PR),
- Benefits Control Plan (BP),
- Provider File (PV), and
- MassHealth Enhanced Eligibility (MHEE).

The figure on page 8 shows an overview of the file types and their content.

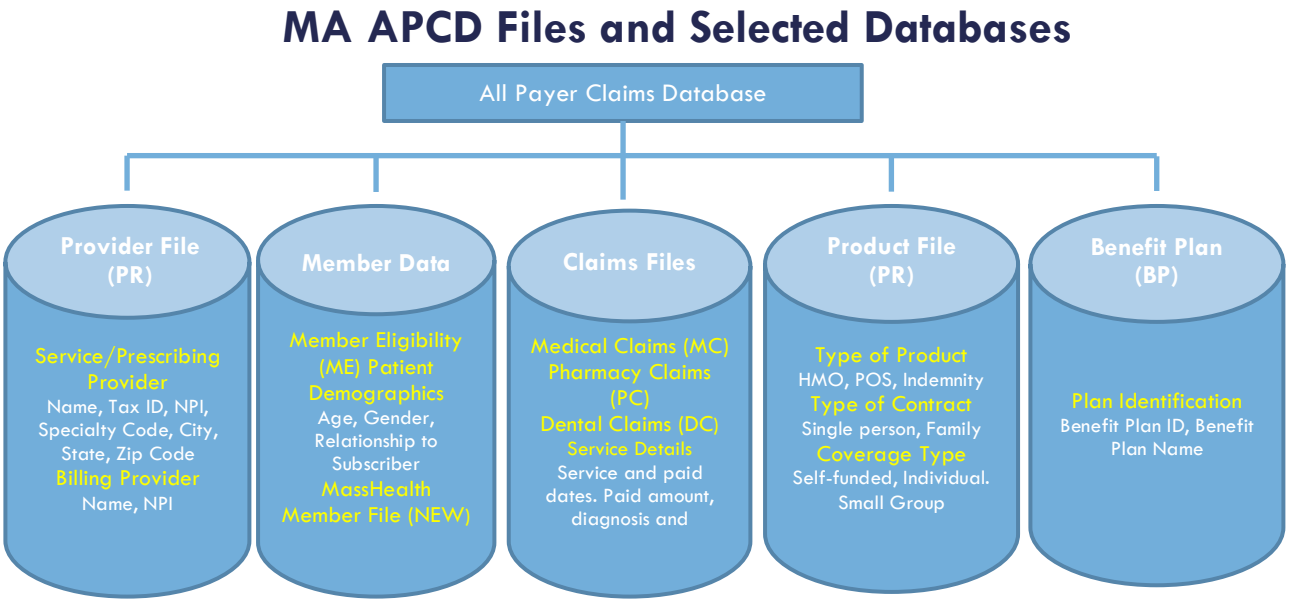

FIGURE 1. MA APCD FILE TYPES

Establishment of the Massachusetts APCD

The first efforts to collect claim-level detail from payers in Massachusetts began in 2006 when the Massachusetts Health Care Quality and Cost Council (HCQCC) was established, pursuant to legislation in 2006, to monitor the Commonwealth's health care system and disseminate cost and quality information to consumers. Initially, data was collected by a third party on behalf of HCQCC under contract. On July 1, 2009, the Division of Health Care Finance and Policy (DHCFP) assumed responsibility for receiving secure file transmissions, creating, maintaining and applying edit criteria, storing the edited data, and creating analytical public use files. By July 2010, Regulations 114.5 CMR 21.00 and 114.5 CMR 22.00 became effective, establishing the APCD in Massachusetts.

Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," created the Center for Health Information and Analysis (CHIA) which assumed many of the functions – including management of the MA APCD – that were previously performed by the Division of Health Care Finance and Policy (DHCFP).

One of the purposes of MA-APCD is administrative simplification. CHIA collects, stores, and maintains data from payer and provider claims databases. The Center serves as a central location for the information technology infrastructure (hardware, components, servers and personnel) necessary to carry out its mission. All other agencies, authorities, councils, boards and commissions of the commonwealth seeking health care data use CHIA-collected data rather than data directly from health care providers and payers. In *order* to ensure patient data confidentiality, the center does not contract or transfer the operation of the database or its functions to any third-parties, such as nonprofit organization or governmental agencies. However, the Center may enter into an interagency services agreement for transfer and use of the data.

A Preliminary Release of the MA APCD covering dates of service CY 2008-2010 was released in 2012. Release 4.0 covers dates of service CY 2010-2014 (paid through June 30, 2015).

MA APCD Release 4.0 Overview

The MA APCD contains data elements collected from all private and public payers of eligible health care claims for Massachusetts Residents. The data is collected in eight file types:

1. Dental Claims (DC),
2. Medical Claims (MC),
3. Pharmacy Claims (PC),
4. Member Eligibility (ME),
5. Product (PR),
6. Benefit Plan (BP) Control),
7. Provider (PV), and
8. MassHealth Enhanced Eligibility.

Each is described separately in this document.

Highlights of the release include:

- Data is available for dates of service from January 1, 2010 to December 31, 2014 as paid through June 30, 2015. Data submitted to CHIA after June 2015 is not included in the files.
- Release 4.0 contains more comprehensive and recently updated data, including resubmissions from several large carriers.
- Data elements are classified as either Level 2 or Level 3 data elements. Level 2 include data elements that pose a risk of exposing the identity of an individual patient. Level 3 data elements can contain either direct personal information, such as name, social security number, and date of birth that uniquely identifies an individual or contains one or more of the 18 identifiers specified by HIPAA that comprise confidential data. Refer to the *MA APCD Release 4.0 Data Elements Specification* for listings of Level 2 and Level 3 data elements for each file. You can find the specification at:

  http://www.chiamass.gov/ma-apcd/
- Government users, as defined by CHIA's data release regulation (957 CMR 5.00) may request both Level 2 and Level 3 elements depending on their research needs. Non-government users may request groups of Level 2 data elements, as curated by CHIA into Limited Data Sets. See Non-Government Documentation Guide and Data Elements Specifications publications for details.
- Certain identifying or sensitive data elements are masked in the release in order to protect patient privacy and allow for the linkage of data elements within the same file.
- Some data elements have been derived by CHIA from submission data elements or have been added to the database to aid in versioning and identifying claims (e.g. Unique Record IDs and status flags). Please refer to the *MA APCD Release 4.0 Data Elements Specification* for additional details.
- CHIA data now contains information from the MassHealth Medicaid program.

Note: Submission Guide information is not available for the MassHealth data file.

DATA COLLECTION AND RELEASE PROCESS

The data collected from the payers for the MA APCD is processed by the Data Compliance and Support team. Data Compliance works with the payers to collect the data on a regular, predetermined, basis and ensure that the data is as complete and accurate as possible. The Data Quality Assurance and Data Standardization and Enhancement teams work to clean and standardize the data to the fullest extent possible. Data Standardization relies on external source codes (see *Appendix* A) from outside government agencies, medical and dental associations, and other vendors to ensure that the data collectors properly utilized codes and lookup tables to make data uniform.

Data Collection and Processing for Release

Third Party Administrators (TPAs)

In instances where more than one entity administers a health plan, the health care payer and third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the payer, and once by the TPA.

CHIA's objective is to create a comprehensive all payer claims database that includes data from all health care payers and third-party administrators.

Edit Processing

When payers submit their data to CHIA for the MA APCD, an edits process is run on each file to in accordance with the MA APCD Submission Guides documentation. The automated edits perform an important data quality check on incoming submissions from payers. They identify whether or not the information is in the expected format (for example, alpha vs. numeric), contains invalid characters (for example, negative values, decimals, future dates) or is missing values (that is, nulls). If these edits detect any issues with a file, they are identified and a report is sent to the payer.

Data elements are grouped into four categories (A, B, C, and Z), which indicate their relative analytic value to CHIA and MA APCD users. Refer to the *MA APCD Release 4.0 Data Elements Specification* to view the Edit Level for each Data Element:

- 'A' level fields must meet their MA APCD threshold percentage in order for a file to pass. There is an allowance for up to a 2% variance within the error margin percentage (depending on the data element). If any 'A' level field falls below this percentage it results in a failed file submission for the payer and the payer's CHIA liaison will work with the payer to correct the submission.
- The other categories (B, C, and Z) are also monitored, but the thresholds are not presently enforced.

More detailed MA APCD Submission Guide File Edit documentation can be found at:

http://chiamass.gov/apcd-data-submission-guides

Note: The MA APCD Submission Guides for Release 4.0 do *not* include information about MassHealth Enhanced Eligibility (MHEE) data.

Claim Versioning Overview

CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, voids/back-outs, replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed and approved by each carrier.

Claim versioning allows CHIA to identify specific attributes in claims that may have multiple versions over time and claim type. This section provides an overview of claim versioning. The Claim Line Type Codes, Highest Paid Version Flag, Highest Version Denied Flag, Highest Version Flag, and Fully Denied Claim Flag are most useful for claim versioning.

For information on file-specific versioning, see *Medical Claims File Versioning* on page 22 and *Pharmacy Claims File Versioning* on page 24.

CHANGES TO CLAIM LINES

The Claim Line Type field triggers claim line versioning. The Claim Line Type code determines the action to be taken by CHIA in order to version the claim (see Table 1 below).

TABLE 1.CLAIM LINE TYPE CODES

Claim Type Code	Claim Line Type Description	Action/Source
O	Original	
V	Void	Delete Line Referenced / Provider
R	Replacement	Replace line Referenced /Provider
B	Back Out	Delete Line Referenced / Payer
A	Amendment	Replace Line Referenced / Payer

HIGHEST PAID VERSION FLAG

The VERSIONINDICATOR flag helps users/CHIA determine the highest version of a claim line that was "paid", and is derived as part of the standard versioning production logic. This is the version indicator approved by carriers per discussions with CHIA for MA APCD release and financial analysis purposes. Additionally, some carriers provided custom logic for including/excluding claim lines.

The following table defines the Version values for the VERSIONINDICATOR.

TABLE 2.VERSIONINDICATOR FLAG

Value	Meaning
1	Highest Version Paid
0	Not Highest Version Paid
9	Versioning Not Applied

Typically a value of 1 means that the line was directly paid; however, note that depending on Carrier specific logic it is sometimes possible that payment for that specific line was actually denied, (see Fully Denied Claim flag). However in such a case, the value 1 indicates that payment was included as part of the payment on another line in the same claim collection.

HIGHEST VERSION DENIED FLAG

The purpose of the HIGHESTVERSIONDENIED flag is to identify claim lines within a claim that have been denied. Values are set per as part of CHIA's standard versioning production logic. These values are defined in the following table.

TABLE 3.HIGHESTVERSIONDENIED FLAG

Value	Meaning
1	Is Highest Version Denied
0	Is not Highest Version Denied
9	Highest Version Denied Flag Not Applied

A value of 1 indicates that the claim line was both highest version and payment was denied. For example:

- If HIGHESTVERSIONDENIED =1 and the "VERSIONINDICATOR" = 1, then that means that while this specific claim line was denied, payment for this line was likely included with payment on another line (bundled payment).
- If HIGHESTVERSIONDENIED =1 and "VERSIONINDICATOR" = 0, then that means that this claim line was denied, and that this claim line is the highest version of the claim line.

HIGHEST VERSION FLAG

The HIGHESTVERSIONINDICATOR flag shows claim lines that are the highest version claim line, whether or not the claim line was paid. The following table defines the flag values.

TABLE 4.HIGHESTVERSIONINDICATOR FLAG

Value	Meaning
1	Highest Version claim line
0	Not Highest Version claim line
9	Versioning Not Applied

FULLY DENIED CLAIM FLAG

The FULLYDENIEDCLAIM flag is a claim level attribute, applied at the claim line level. If all the individual claim lines in the highest version of a claim are denied, then the entire claim is a fully denied claim. The same derived claim level value will be applied to each claim line in the collection.

TABLE 5.FULLYDENIEDCLAIM FLAG

Value	Meaning
1	Fully Denied Claim.
0	Not Fully Denied Claim
9	Versioning Not Applied

The logic for assigning these flags requires sorting the dataset and breaking on OrgId and PCCN (Payer Claim Control Number) where Highest Version indicator = 1. This ensures only a highest version claim will be considered a fully denied claim*. Users should expect to see only highest version claims flagged as fully denied (that is: HIGHESTVERSIONINDICATOR = 1 and FULLYDENIEDCLAIM = 1).

> **Note:** Any claim that is not a highest version claim line related to the final version view will *not* be flagged as a fully denied claim as these claim lines are considered a different claim view, separate from the final claims view. Be aware, however, that these types of claims often have the same PCCN as the highest paid version view.

Variance Process

The Variance Process is a collaborative effort between the payer and CHIA to reach a threshold percentage for any data element which may not meet the MA APCD standard. Payers can request a lower threshold for specific fields, but they must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. CHIA staff reviews each request and follows up with the payer for a variety of reasons, including improving data quality, suggesting alternative threshold rates or by creating plans to reach the threshold over time.

Payers use this process to request certain file type variances (for example. a vision payer requests a variance in submitting pharmacy or dental claim files).

When this process is complete, any submissions from the payer are held to the CHIA standard thresholds and approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. CHIA holds reviews and discussions with the payer about the files that exceed the threshold percentage. The payer must then provide the corrected data for the submission file.

VARIANCE EXAMPLE

Other Diagnosis fields in the Medical Claims file (data elements MC042 – MC053) are examples of fields for which variances have been approved. In requesting the variance, the carrier submitted a business rationale, explaining that in order to the pay claims, it was not necessary to retain more than the Primary or Admitting Diagnosis from claim forms. CHIA accepted the rationale and lower thresholds for these data elements. However, CHIA requested that the carrier should develop a remediation plan to start collecting this information going forward, thus eliminating the need for lower thresholds on these fields and improving the quality of the data.

CHIA VARIANCE ANALYSIS BY DATA ELEMENT

CHIA periodically conducts variance analyses by data element and produces reports. Such reports include the number of payers requesting variances on the indicated data element, the mean of the threshold variance requests, the minimum variance percentage requested, and the maximum variance percentage requested. Users who would like more details about this analysis may contact CHIA at:

apcd.data@state.ma.us

Data Release Processing for Release

Restricted Release Files

The Restricted Release File has the following characteristics:

- Each file type is written to a separate asterisk delimited file. Each row in the release file represents one record of the file type. There is an asterisk-delimited field in each row for every data element listed in the *MA APCD Release 4.0 Data Elements Specification.*
- Data Elements are delimited as shown in the *MA APCD Release 4.0 Data Elements Specification.*
- Empty or null data elements have no spaces or characters between the asterisks.
    - With the exception of the MHEE data elements, lookup tables are listed in the intake Submission Guides for each file type. You can find the Guides at:

      http://www.chiamass.gov/apcd-data-submission-guides/
    - External Code Sources support lookup table references in the Submission Guide. See *Appendix A* for additional information.
    - Hashed Elements: For the Data Release, some of the data elements have been hashed to provide confidentiality for Payers, Providers and individuals, while allowing for linkage between claims, files, and lookup tables.

DATA MASKING

In order to protect the privacy of individuals whose health information is contained in the MA APCD, CHIA has applied masking procedures on certain MA APCD Data Elements prior to release. Masked elements are defined in the *MA APCD Release 4.0 Data Elements Specification.*

> **Note:** Masking indicates that a field's contents are replaced in the output extract file (i.e., *masked* output that creates the same random value each time for a specific source value).

Null values are excluded from masking to eliminate a possible result of false linking due to masked Null values that appear to match. Any Null value found in masked fields produces an empty (zero length) field in the Release files.

Redaction and Data Standardization

REDACTION

In order to protect against the unintended disclosure of SSN data, certain data elements were subjected to a redaction process.

> Redaction indicates that a field has been scanned and suspected or possible SSN values have been set to null.

SSN redaction was applied against any field or data element that could not otherwise be validated against reference tables.

For a list of data elements that were redacted using the above process, please refer to the *MA APCD Release 4.0 Data Elements Specification.*

DATA STANDARDIZATION USING MELISSA DATA

Melissa Data Corp. specializes in global contact data quality and mailing preparation for small businesses and large enterprises that to help improve contact data. CHIA validates demographically-related elements (i.e. Member Zip Code, Service Provider State, etc.) using Melissa Data software for the purpose of standardizing demographic elements to ensure consistent formatting of data fields across the database. For a list of data elements that were standardized using the Melissa Data software application, please refer to the *MA APCD Release 4.0 Data Elements Specification.*

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see Redaction and Data Standardization above).

Linking Across File Types

DATA HASHING AND FILE LINKING

The Claims file links to files using these data elements:

- Linking Plan Provider ID (PV002)+ Provider Delegate (Derived PV9) and/or
- Linking Product ID (PR001)+Product Delegate (Derived PR3), respectively.

When values have been hashed using *integer* values linkages can still be performed. See **Error! Reference source not found.** for specific references.

Member Entity Identification Element (MEID)

CHIA provides a derived element (Member Link EID) that represents a unique Enterprise ID (EID) of an individual member (person entity). This number can be used to link an individual across all filing types - Eligibility, and Claims (Medical, Pharmacy, Dental). See **Error! Reference source not found.** for specific data element references.

Benefit Plan Control (BP) File Linkage

The Benefit Plan Control File links to the Member Eligibility File, rather than a Claim file. The data elements in the BP file have been assigned to the Level 3 Release Level, which is a restricted release element. As a result, the linkage elements have not been re-identified. These elements are Linkage Elements: BP001 Benefit Plan Contract ID to ME128 Benefit Plan Contract ID.

Table 6 listed the linked data elements by file type.

TABLE 6.LINKED DATA ELEMENTS BY FILE TYPE

File	Element Code	Data Element Name
BP	BP001	Benefit Plan Control ID
DC	DC018	Service Provider Number
DC	DC042	Product ID Number
DC	Derived DC11	Member Link EID
MC	MC024	Service Provider Number
MC	MC076	Billing Provider Number
MC	MC079	Product ID Number
MC	MC112	Referring Provider ID
MC	MC125	Attending Provider
MC	MC134	Plan Rendering Provider Identifier
MC	MC135	Provider Location
MC	Derived MC16	Member Link EID
ME	ME036	Health Care Home (PCMH) Number
ME	ME040	Product ID Number
ME	ME046	Member PCP ID
ME	ME124	Attributed PCP Provider ID
ME	Derived ME13	Member Link EID
PC	PC043	Prescribing Provider ID
PC	PC056	Product ID Number
PC	PC059	Recipient PCP ID
PC	Derived PC12	Member Link EID
PR	PR001	Product ID
PR	Derived PR3	Product Delegate
PV	PV002	Provider ID
PV	PV054	Medical / Healthcare Home ID
PV	PV056	Provider Affiliation
PV	Derived PV9	Provider Delegate
*MHEE		HashCarrierSpecificUniqueMemberID
*MHEE		HashNewMMISID

*** MHEE = MassHealth Enhanced Eligibility. This file does not currently use Element Code detail as represented for other file types in the MA APCD Submission Guides.**

Data Limitations

Researchers using the MA APCD Release 4.0 data should be aware of the following:

- Due to the variance process, data quality may vary from one payer to another. (*Variance Process* on page 11 in this document.)
- Claim Files submitted through June 2015 were accepted with relaxed edits. (Refer to the MA APCD Submission Guide for Edit information)
- The release files contain the data submitted to CHIA including valid and invalid values.
- Certain data elements were cleaned when necessary. Cleaning applies to the masking of data that may uniquely identify patients, doctors, etc. Details on cleaning are provided at the end of each file chapter.
- Certain data elements were redacted to protect against disclosure of sensitive information.
    - Some Release Data was manipulated to protect patient privacy:
        - Linkage IDs were Hashed to integral values to mask values while retaining linkage,
        - Carrier-specific IDs were hashed,
        - Member Birth Year is reported as 999 for all records where the member age was reported as older than 89 years on the date of service.
        - Member Birth Year is reported as null for all records where the member was reported as older than 115 years on the date of service.

For more information, see Table 6 *Linking Across File Types*.

DENTAL CLAIMS (DC) FILE

As part of the Massachusetts All Payer Claims Database (MA APCD), payers are required to submit a Dental Claims File. The Dental Claims File will release claim lines organized by Date of Service To for each requested year. In the event that Date of Service To is unavailable, Submission Month Period will be used to filter data.

Payers are instructed by CHIA to submit any dental claim that is considered paid. The paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly for claims that are paid under a *global payment*, or *capitated payment*, and thus are zero paid

Below we have provided details on business rules, data definitions, and the potential uses of this data.

File Characteristics

Each row in the MA APCD Dental Claims file represents one claim line. If there are multiple services performed and billed on a claim, each of those services are uniquely identified and reported on a line. Line item data provides an understanding of how services are utilized and adjudicated by different payers.

Certain data elements of claim level data are repeated in every row in order to report unique line item processing and maintain a link between line item processing and claim level data.

Dental File Claim Lines

Claim ID

Claims may be isolated by grouping claim lines by the following elements:

Payer Org ID (DC001) + Payer Claim Control Number (DC004)

Denied Claim Lines

Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported. Denied line items of an adjudicated claim may aid with analysis in the MA APCD in terms of covered benefits and/or eligibility.

Types of Data Collected in the Dental Claims File

Payer-assigned Identifiers

CHIA requires various payer-assigned identifiers for matching logic to other files, i.e., Product File and Member Eligibility. Examples of these fields include DC003, DC006, DC056 and DC057. These fields can be used to aid with the matching algorithm to other files.

DC Claims Data

CHIA requires line-level detail of all Dental Claims for analysis. The line-level data aids with understanding utilization within products across Payers. Subscriber and Member (Patient) Payer unique identifiers (DC056 and DC057) are included to aid with the matching algorithm.

Non-Massachusetts Residents

CHIA waives the submittal of claims data for employer groups whose employees reside outside of Massachusetts. However, if the payer is contracted with the Group Insurance Commission (GIC), then CHIA requires submittal data for non-residents.

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are DC017, DC030, DC031, DC037 through DC041, DC045, DC046 and are variations of paper remittances or as defined by HIPAA 835 4010.

Denied Claims

CHIA does not require payers to submit claims rejected in total.

> **Note:** The provider must submit data for partially paid claims.

The Dental Claims Provider ID

Element DC018 (Provider ID) is a critical element in the MA APCD. It links the Provider identified on the Dental Claims file with the corresponding record in the Provider File (PV002)/ Provider Delegate (Derived PV9).

The purpose of PV002/Derived PV9 is twofold: to help identify provider data elements associated with provider data, submitted in the claim line, and to identify the details of the Provider Affiliation.

PV002 frequently contains sensitive personal information; therefore CHIA has hashed this element in the current release. This allows linking to the PV file Provider ID. See also Linking Across File Types for greater detail on this process.

MEDICAL CLAIMS (MC) FILE

As part of the MA APCD, payers are required to submit a Medical Claims File. The Medical Claims File consists of all final paid claims from all reporting payers segregated by Date of Service in 2010, 2011, 2012, 2013, and 2014 as reported through June 2015. (This represents a six month plus run-out period of 2014 data.)

The Medical Claims File will be released for each requested year based on Date of Service To for the claim line. In the event that Date of Service To is unavailable, the following will be utilized:

- Discharge Date
- Date of Service From or Admit Date; or
- Submission Month Period.

For a full list of elements refer to the *MA APCD Release 4.0 Data Elements Specification*.

Payers are instructed by CHIA to submit any medical claim that is defined as paid. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly. Claims that are paid under a *global payment*, or *capitated payment*, thus are zero paid.

Medical File Characteristics

Certain data elements of claim level data are repeated in every row in order to report unique line item processing. Claim-line level data is required to capture accurate details of claims and encounters.

The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.

Claims may be isolated by grouping claim lines by the following elements:

Payer Claim Control Number (MC004)/Payer Org ID (MC001)

Types of Data Collected in the Medical Claims File

Payer-assigned Identifiers

CHIA requires various Payer-assigned identifiers for matching-logic to the other files, for instance, the Product File and Member Eligibility file. Examples of this type of field include MC003, MC006, MC137 and MC141.

Claims Data

CHIA requires the line-level detail of all Medical Claims for analysis, which aids with identifying utilization within products across Payers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC127, MC129, MC130, and MC136 are the same as the elements that are reported to a Payer on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Payer specific direct data entry system.

Subscriber and Member (Patient) Payer unique identifiers are collected to aid with the matching algorithm, see MC137 and MC141.

Fields MC024-MC035 - Servicing Provider Data

The set of fields MC024-MC035 relate to the servicing provider entity. The intent is to collect entity level rendering provider information, at the lowest level achievable by the payer. A physician's office is also

appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

If the payer only knows the billing entity, and the billing entity is not a *service rendering* provider, the payer would need a variance request for the service provider fields.

If the payer only has the data for a main *service rendering* site but not the specific satellite information where services are rendered, then the main service site *is* acceptable for the service provider fields.

For example, XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and, ultimately, the goal.

Fields MC134 (Plan Rendering Provider) and MC135 (Provider Location)

The intent of these fields is to capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely who and where the service was rendered. If the payer does not know who actually performed the service or the specific site where the service was actually performed, the payer will need a variance request for one or both of these fields. It is not appropriate to report facility or billing information here.

Non-Massachusetts Residents

CHIA does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission (GIC).

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

Denied Claims

Payers are not required to submit wholly denied claims.

> **Note**: The provider must submit data for partially paid claims.

The Medical Claims Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are critical fields in the MA APCD; they are used to link the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002)/ Provider Delegate (Derived PV9) in the Provider File. (See The Provider ID for more information.)

The purpose of PV002/Derived PV9 is to help identify provider data elements associated with provider data submitted in the claim line detail, and to identify the details of the Provider Affiliation. However, due to the fact that PV002 may contain sensitive personal information, PV002 has been hashed for this release by CHIA, which allows linking to the Provider File. Refer to *Linking Across File Types* for greater detail on this process.

Medical Claims File Versioning

Highest Version Flag created for Medical Claims Files has the following characteristics:

- Data Element Name: Highest Version Flag (Derived-MC10)
- CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, voids/back -outs, and replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed with each carrier.
- A highest versioning flag is used in Release 4.0. A value of 0 or 1 has been assigned to each medical claim line from the following carriers: 290, 293, 295, 296, 300, 301, 3156, and 3505. 3735, 4962, 7041, 7422, 7655, 8026, 8647, 10353, 10441, 10442, 10647, 10920, 10929, 11215, 11474, 11701, 11726, partial on 10632. Claim lines from all other carriers should have a value of 9. (See also *Claim Versioning Overview* on 11.) [1]
- Data Limitations: OrgID 10632 has been versioned from May 2013 forward. Any data prior to May 2013 is not versioned.

[1] For services rendered on or after 3/1/2010 only. Claim lines for services rendered before 3/1/2010 should have a value of 9.

PHARMACY CLAIMS (PC) FILE

As part of the MA APCD, payers will be required to submit a Pharmacy Claims File. The Pharmacy Claims File includes individual claim lines for each requested year. The Pharmacy Claims lines are are assigned a *Date of Service To*. In the event that *Date of Service To* is unavailable, the following data elements are used:

- DatePrescriptionFilled;
- Paid Date;
- DatePrescriptionWritten;
- DateOfServiceApproved; or
- Submission Period (YYYMM) less 1 day.

CHIA assigns a release ID for each claim line in the Pharmacy file. The Release ID is a unique ID for each claim in the data release.

CHIA instructs payers to submit any pharmacy claim that is considered paid. Claims paid under a *global payment* or *capitated payment* are designated zero (0) paid. Payers should report the Paid amount as 0 and the corresponding *Allowed*, *Contractual*, and *Deductible Amounts* should be calculated accordingly.

Below we have provided details on business rules, data definitions, and the potential uses of this data.

Types of Data Collected in the Pharmacy Claims File

Payer-assigned Identifiers

CHIA collects various Payer-assigned identifiers for matching-logic to the other files, i.e., Product File and Member Eligibility. Examples of these fields include PC003, PC006, PC107 and PC108. These fields can be linked using matching algorithm across other file types.

Claims Data

CHIA requires line-level detail of all Pharmacy Claims for analysis. The line-level data aids with understanding utilization within products across Payers. Subscriber and Member (Patient) Payer unique identifiers included linked data using the matching algorithms; see the data elements PC107 and PC108. See also *Linking Across File Types* on page 15.

Non-Massachusetts Resident

CHIA does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required to by contract with the Group Insurance Commission (GIC).

Adjudication Data

CHIA requires adjudication-centric data in order to comply with analytic requirements. The elements typically used in an adjudication process are PC017, PC025, PC036, PC040 through PC042, PC063, PC065 through PC070 and PC110 and are variations of paper remittances or HIPAA 835 4010.

Denied Claims

CHIA does not require payers to submit wholly denied claims.

> **Note:** The provider *must* submit data for all claims paid partially or in whole.

Provider Identifiers

CHIA collects numerous identifiers that may be associated with a provider. The identifiers will be used to help link providers across payers in the event that the primary linking data elements are not a complete match. The additional identifying elements will improve the quality of the matching algorithms. Examples of these identifying elements include PC043-PC055 relating to the Prescribing Provider.

The Pharmacy File Provider ID

Elements PC043 (Prescribing Provider ID) and PC048 (Prescribing Physician NPI) are critical fields which link the Prescribing Provider identified on the Pharmacy Claims file with the corresponding record in the Provider File (PV002)/Provider Delegate (Derived PV9). See The Provider ID for more information.

The purpose of PV002/Derived PV9 are twofold; to help identify provider data elements associated with provider data, submitted in the claim line detail, and to identify the details of the Provider Affiliation. However, because PV002 may contain sensitive personal information, PV002 has been hashed by CHIA for this release. This allows linking to the Provider File. (Also see *Linking Across File Types* and *Appendix* B for additional information on file linking.)

Pharmacy Claims File Versioning

For linkage purposes, the *same re-identified integer values* were substituted into the Pharmacy file. (See the *Claim Versioning Overview* on page 11 for supplemental information.)

A highest version flag is provided in Release 4.0. A value of 0 or 1 has been assigned to each Pharmacy file claim line from the following carriers: MassHealth (3156), BCBS of MA (291), Harvard Pilgrim Health Plan (300), and Tufts Health Plan (8647[2]) for incurred periods January 2010 through December 2014. Claim lines from all other carriers have a value of 9.

Claim ID

Claims may be isolated by grouping claim lines by the following elements:

Payer Claim Control Number (PC004) + Payer Org ID (PC001)

Denied Claim Lines

Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported. Denied line items of an adjudicated claim may aid with analysis in the MA APCD in terms of covered benefits and/or eligibility.

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[2] Medicare claim lines for pharmacy services incurred in 2012, 2013, and 2014 have not been versioned and, therefore, contain a value of 9 for Tufts Health Plan.

MEMBER ELIGIBILITY (ME) FILE

As part of the MA APCD, payers are required to submit a Member Eligibility file. Annual eligibility files contain all eligibility records with at least one day of member eligibility within the calendar year. For Release 4.0, one file per year will be released (e.g. December 2010, and forward). Each year's Eligibility File will contain a 24-month rollback of eligibility. If data from 2010-2012 is requested, then three Eligibility Files will be released (December 2010, December 2011, and December 2012).

There are a number of elements in the ME file (for example, members date of death,) that are poorly reported. Individual elements each have a reporting threshold setting, which allows Payers to meet reporting requirements. The variance process allows for Payers to address any inability to meet threshold requirements. See *Variance Process* on page 13 for additional information.

Types of Data Collected in the Member Eligibility File

General Data Characteristics

If a Member is eligible for more than one Product, then the Member will be reported on multiple records in the same month.

If a Member has more than one Primary Care Physician (PCP) under the same Product, then the Member and Product will be reported on multiple records in the same month.

If a member has a break in eligibility, this results multiple records.

A break in eligibility allows for the opportunity to analyze information on Member Eligibility by Products and Member Eligibility by Claims, to better understand utilization. CHIA uses enrollment data to calculate member months by product and by provider.

Coverage attributes such as PCP should reflect the values most relevant to:

- The end period for the Eligibility segment (if an inactive segment) or
- The Member Eligibility file end period (e.g. 12/31/2009).

Subscriber/Member Information

The file includes both member and subscriber information; however, information on eligibility relates strictly to the *member*, who may or may not be the subscriber. CHIA primarily uses provider-supplied data to link a member to a subscriber...

Non-Massachusetts Residents

CHIA does not require payers who submit eligibility data on behalf of an employer group to submit eligibility data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission.

Coverage Indicators

CHIA collects coverage indicator flags indicating a member has medical, dental, pharmacy, behavioral health, vision and/or lab coverage. These fields can be compared against the Product file and are helpful in understanding benefit design.

Dates

CHIA collects two sets of start and end dates:

- ME041 and ME042 are the dates associated with the member's enrollment with a specific product. ME041 captures the date the member enrolled in the product and ME042 captures the end date or is Null if they are still enrolled.
- ME047 and ME048 are the dates a member is enrolled with a specific PCP. For plans or products without PCPs, these fields will not be populated.

Member Eligibility File Features

CHIA defines the ME File detail level as at least one record per member, per Product ID, per beginning and ending date of eligibility for that product. Each row represents a unique instance of a Member and their Product Eligibility and other attributes. Multiple records for "Member and Product" may exist, but begin and end eligibility dates within a product should not overlap. Only a product change, or break in eligibility, triggers a requirement for a new eligibility record.

Multiple Rows in the ME File

The ME File contains *one record per member per product per eligibility time period*. For example, if medical and pharmacy benefits are delivered via two separate products rather than a bundled product (that is, HMO Medical 1000 and RX Bronze) we expect two records, one for HMO Medical 1000 and one for RX Bronze. In this example, the Medical Coverage indicator (ME020) would have a value of one (1) for Yes and the Prescription Drug Coverage indicator (ME019) would have a value of two (2) for No in the HMO Medical 1000 eligibility record. These field values would be reversed in the RX Bronze eligibility record.

ME File Impact on Product File (PR) Entries

This convention (*one record per member per product per eligibility time period*) also impacts the Product File. Each product listed in the ME File also must be present in the Product File, with PR006 indicating that the product is a Pharmacy, Medical or other product. The product Benefit Type should correlate to the flags in the Member Eligibility File. For example, for the Product File record for the HMO Medical 1000 we would expect PR006 product Benefit Type to be one (1), which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of two (2) for 'Pharmacy Only' in PR006.

Redundancy in ME Claims Data Elements

Many of the segments in the file use semantics similar to claims data, and some fields are exact duplicates of fields in claims files. CHIA collects contents of the Payer's Member File regardless of the information contained in Claims files. This extra or similar information across files is needed to support analysis of the variations of Member Eligibility. It is also a requirement of other states.

Member's Date of Death

The Member's Date of Death data element indicates the end of a Member's Eligibility. It is reported only when known as some Providers do not track the member's date of death.

PRODUCT (PR) FILE

As part of the MA APCD, payers are required to submit a Product File. Release 4.0 has one Product File that consists of aggregated and unduplicated records across multiple years.

Product Definition

A Product, often described by the business model that it conforms to, starts as a base offering, for example, HMO, PPO, Indemnity, etc.

Product Line of Business Model (PR004) is collected by the MA APCD to define the type of business model. The data must be submitted using a CHIA-provided lookup table, which can be found in the *MA APCD Release 4.0 Data Elements Specification,* located on the CHIA MA APCD *web site*:

http://www.chiamass.gov/ma-apcd/

Below are details on business rules, data definitions, and the potential uses of this data. For a full list of elements refer to the Release 4.0 Data Elements Specification mentioned above.

The Release 4.0 Product File

Release files are in an asterisk delimited text file in the same order as found in the *MA APCD Release 4.0 Data Elements Specification*. Empty or null data elements have no spaces or characters between the asterisks. Each user receives only the data elements requested and approved.

Each row represents a unique instance of a Product. However, some payers have reported products on separate rows that differ only in aspects that are not specified in the Product File. Therefore, for some payers there may be appear to be duplicate rows when, in fact, they are distinct products.

Types of Data Collected in the Product File

Product Identifiers

CHIA collects elementary identifiers associated with a Product. The data in fields PR002 through PR008 can be used when analyzing Product data across payers. The identifiers help to link Product data to the Member Eligibility File.

Product Dates

CHIA collects two date fields for each Product record. The Start and End Dates (PR009 and PR010) for each Product describes the dates the Product was active with the payer and usable by eligible members. For Products that were still active at the end of 2011, the End Date should be Null. For Products that were not active, but may still have claims being adjudicated against them, the End Date should be the End Date reported to the Division of Insurance *or* the date the license was terminated.

Products Not Defined in the Lookup Table for PR004

Use the Data Elements in Table 7 to report other Product descriptions.

TABLE 7.ADDITIONAL LINES OF BUSINESS

Element	Element Name	Submission Guideline
PR004	Product Line of Business	ZZ
PR007	Other Product description	Payer enters the name of the line of business

By reporting the Model Code of ZZ, which is mutually defined by CHIA and Payers, the Payer has flexibility in reporting the name of the business model as further defined in PR007. ZZ is the default value, which directs the user to the PR007 value. Because payers store their Product data in a variety of formats and data structures, CHIA uses this methodology to allow for easier analysis of Product data.

BENEFIT PLAN CONTROL FILE

In connection with the Massachusetts Risk Adjustment program, a Benefit Plan Control Total File (BP) has been added to the MA APCD. All submitters participating in the Massachusetts Risk Adjustment program are required to submit a Benefit Plan Control Total File for their Risk Adjustment Covered Plans (RACPs). The Benefit Plan Control Total File requires data for all RACPs offered in Massachusetts. Submitters are not required to submit Benefit Plan Control Total File data for their Non-RACP plans.

Types of Data Collected in the Benefit Plan Control File:

Non-Massachusetts Residents

Under Administrative Bulletin 13-02, CHIA is reinstating the requirement that payers submitting claims and encounter data on behalf of an employer group submit claims and encounter data for employees who reside outside of Massachusetts.

CHIA requires data submission for employees that are based in Massachusetts whether the employer is based in MA or the employer has a site in Massachusetts that employs individuals. This requirement is for all payers that are licensed by the MA Division of Insurance, are involved in the MA Health Connector's Risk Adjustment Program, or are required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Submitter-Assigned Identifiers

CHIA requires various Submitter-assigned identifiers for linking to the other files. Some examples of these elements include the Benefit Plan Contract ID (BP001 and ME128). These elements are used by CHIA and the Health Connector to link members across different files, conduct all risk adjustment calculations and reporting to carriers. Failure to provide the proper identifiers will result in inaccurate risk adjustment funds transfers for the data submitter as well as all others subject to risk adjustment.

Control Total Data

The claim counts, member counts and dollar amounts should align to the detail claims submitted to the MA APCD, for the same reporting month for the RACP plans.

- Each row, or Detail Record, contains the information for a unique Benefit Plan Contract ID and Claim Type (Medical or Pharmacy) within the Submission Period.
- Each row also contains a provider's begin and end date.

This information can be used to analyze data on providers, clinicians, hospitals, physician groups and integrated delivery systems.

This detailed level is necessary for aggregation and reporting for the Risk Adjustment Methodology.

THE PROVIDER (PV) FILE

CHIA collects date provider data, which can be used to analyze claims data when submitted in accordance with Submission Guide Standards. Since claims data is collected monthly, the provider file can be synced with the claims file, and provides a snapshot of how the provider file looked at the end of the period for which claims are sent.

The PV File is a compilation of all payer provider files. A unique provider record exists for *each instance* where the provider is found in a payer submission. A provider record may also repeat within a payer for each attribute change. (See the *Qualifiers* section below).

> **Note:** Providers who have not been active since January 2008 do not need to be included in the collection process; however, some payers have elected to do so.

This section provides details on business rules, data definitions, and the potential uses of this data.

Provider Definition

CHIA defines a Provider as an organization or person that is:

- Providing services to patients, and/or
- Submitting claims for services on behalf of a servicing provider, and/or
- Providing business services or contracting arrangements for a servicing provider.

A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.

The Release 4.0 Provider File

Each row represents a unique instance of a provider entity within a payer, and may repeat rows for each attribute change, such as:

- affiliation to another entity, or,
- a provider's affiliation to a specific location, or,
- a provider's begin and end date.

Types of Data Collected in the Provider File

Provider Linkage

CHIA collects numerous identifiers that may be associated with a provider. CHIA uses these identifiers to link providers across payers in the event that the primary linking data elements are not a complete match. These extra identifying elements improve the quality of the matching algorithms. Please refer to ***Error! Reference source not found.*** on page **Error! Bookmark not defined.** for additional information.

Demographics

CHIA collects address information on each provider entity to meet reporting and analysis requirements. Additional demographic data elements such as Gender and Date of Birth for the provider are collected for use in linking providers across payers. These two fields can be used, when provided, help increase the

quality of the matching algorithms across payers. CHIA has also standardized Address and Zip Code data where possible.

Provider Specialty

The required fields are Taxonomy (PV022), Provider Type Code (PV029), and Provider Specialty (PV030, PV043, and PV044) and can be used to meet reporting and analysis requirements including clinical groupings and provider specific reports. Each payer submits its internal code sets (lookup tables) to CHIA for these fields. See the MA APCD Release 4.0 Data Elements Specification for additional information.

Start and End Dates

CHIA collects *two sets of date fields* for each provider record. The sets of data are the Beginning and End Date for each provider and the Provider Affiliation Start and Provider Affiliation End Date. They are defined as follows:

- **The Begin and End date for each provider (PV037 and PV038)** describes the dates the provider is active with the payer and is eligible to provide services to members. For providers who are still active the End date should be Null.
- **The Provider Affiliation Start and Provider Affiliation End Date (PV062 and PV063)** describe the providers' affiliation/association with a parent entity, such as a billing entity, corporate entity, doctor's office, provider group, or integrated delivery system. Each unique instance of these start and end dates *must* be submitted as a separate record on this file. If a provider was active and termed in the past with the payer, and was added back as an active provider, each instance of those 'active' dates should be provided, one for each time span. Similarly, each instance of a provider affiliation, and those associated dates should be provided in a record. If a provider has always been active with a payer since 2008, but has changed affiliations once, there would be two records submitted as well, one for each affiliation and those respective dates. If a provider's affiliation is terminated, and is made active again at a later date, this would require two records as well.

Note: Date Fields and Qualifiers may be poorly represented in the data. Providers do not always collect this information and, therefore, these fields may not be adequately populated.

Qualifiers

CHIA collects provider information related to healthcare reform, electronic medical records, and patient centered medical homes. These data elements are not always captured by the payer's core systems. The thresholds for these fields are lower in the short term to allow providers and payers more time to capture and submit this information.

Examples:

1. **Individual Provider practicing within one doctor's office or group and only one physical office location.**

   A provider fitting this description should have one record per active time span. The record would contain information about the provider (Dr. Jones) and the affiliation fields would indicate that Dr. Jones practices or contracts with (ABC Medical). ABC Medical, since it is a group, would have its own separate record as well in this file. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

2. **Individual Provider practicing within an office they own.**

   A provider fitting this description should have one record per active time span for their individual information (Dr. Jones) and a second record for their practice, Dr. Jones Family Care. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

3. **Individual Provider practicing within an office they own or for a practice they do not own across two physical locations**.

   A provider fitting this description should have two records per active time span. The office, affiliation or entity that the doctor does business under (ABC Medical, Dr. Jones family medicine) would have only one additional record.

4. **Individual Provider practicing across two groups or different affiliations.**

   A provider fitting this description should have two records per active time span, one for each group/entity they are affiliated with. Each group/entity would have its own separate record as well.

5. **Entity, Group or Office in one location**

   An entity fitting this description should have one record per active time span. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records.

6. **Entity, Group or Office in two locations**

   An entity fitting this description should have two records per active time span, one for each location. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records. If these affiliated entities and providers are associated with just one of the locations, they would have one corresponding record. If they are affiliated with each of the parent entity's locations, they should have one record for each location, as in Example 3.

7. **Billing organizations**

   An entity that shows up in the claims file in the Billing Provider field should also have a corresponding provider record. Medical Billing Associates, Inc. should have one record for each location and identifier it bills under as determined by the claims file.

8. **Integrated Delivery Systems**

   Organizations such as Partners Healthcare or Atrius Health should have their own record if the payer has a contract with those entities. All entities, groups or providers affiliated with the Organization should have the Provider ID of this entity in the Provider Affiliation Field. Entities meeting a description similar to an Integrated Delivery System should show up one time in the provider file.

The Provider ID

Provider IDs (found in all three claims files) are some of the most critical fields in the MA APCD process as they link the Provider identified on the claims file with the corresponding record in the Provider File (PV002). The definition of PV002, Provider ID, is:

> "…the unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a payer has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file."

PV002 and Product Delegate (Derived PV9) help identify the provider data elements submitted in the claim line detail, and to identify the details of the Provider Affiliation. Since PV002 frequently contains sensitive personal information, CHIA applied a substitution age element to this element for this release. This substituted element provides linkage to the Provider File. Refer to *Linking Across File Types* for addition information on this process.

MASSHEALTH ENHANCED ELIGIBILITY

Release 4.0 includes MassHealth Enhanced Eligibility (MHEE) data. Because MHEE data is constructed differently than that of commercial health plans, the MassHealth MA APCD Enhanced Eligibility file poses analytic challenges to determining population segments, provider information, coverage segments, etc.

Unlike commercial health plans, MassHealth eligibility plans and coverage categories fluctuate regularly. As a result, CHIA requires a monthly eligibility submission from the MassHealth Data Warehouse. CHIA uses these monthly submissions in addition to typically submitted MA APCD data files to accurately analyze and report on MassHealth membership.

MassHealth Enhanced Eligibility (MHEE) Data

The MassHealth Enhanced Eligibility data is an extensive data source derived by and stored in the Executive Office of Health and Human Services Data Warehouse (EHS DW). It combines Medicaid Management Information System (MMIS) eligibility, managed care enrollment, Long Term Care (LTC) residency, Medicare eligibility and other member information into a single analytic resource, with non-overlapping effective dates. As a result, it provides a comprehensive view of a member on any given day. Because dates do not overlap, this data readily lends itself to member month summary reporting.

MassHealth Enhanced Eligibility is a critical data source for essentially all of the member month and Per Member Per Month (PMPM) cost reporting. The information primarily exists in a single data table in the EHS DW named NW_STATE_ELIGIBILITY. However links to provider and member data are necessary to capture member demographics and provider details (e.g., Managed Care Entity (MCE) and Primary Care Clinician (PCC) provider IDs, type and names). CHIA receives this data from the EHS Data Warehouse team as a single enhanced eligibility data file submission.

MHEE data is Level 3, and therefore use requires approval of MassHealth. The purpose of this data is to supplement the standard Member Eligibility (ME) filing data with data submitted by MassHealth only. The MHEE data file consists of MassHealth data only. The data for the years 2012 thru 2014 (January-December) was submitted to CHIA and has been compiled into a format specifically intended to simplify usage by analysts in tandem with CHIA's other MA APCD Release data.

MHEE Data Characteristics

Each record or row in the *MA APCD Release 4.0 Data Elements Specification* represents an active time span or segment of relevant eligibility and enrollment for a member. You can find this specification on the CHIA MA APCD web site:

http://www.chiamass.gov/ma-apcd/

A member s identified by the unique carrier specific column name:

HASHCARRIERSPECIFICUNIQUEMEMBERID

This field can be used to link to the MA APCD ME file to gain additional member attributes not included in the MHEE file.

Date intervals (or spans) reflect a period of time for which the eligibility and enrollment status reflected in the record applies. These dates do not necessarily reflect the actual beginning or ending of eligibility or enrollment, rather they allow for the determination of eligibility and enrollment status of a member on any given day.

Date intervals on any segment do not cross over a monthly boundary. CHIA created monthly bounded eligibility spans, so that each month can stand on its own as a record of eligibility time intervals. This design

allows reconstruction of any desired interval of eligibility by using date parameters to select a collection of monthly segments.

Effective dates of enrollment are Monthly bounded values

dte_effective	**DTE_EFFECTIVE_Month**	(segment beginning YYYYMMDD)
dte_end	**DTE_END_Month**	(segment end YYYYMMDD)

Example: To select all the eligibility segments for calendar year 2014:

Select records where:

Dte_effective_month between "20140101" and "20141231"

While each eligibility segment spans no more than one month, there are as many segments within a month as there are discrete combinations of eligible time spans and aid categories. It is theoretically possible for a member to have as many segments as there are days in the month. Each time a new aid category is assigned, or other eligibility or enrollment changes, there is a new segment.

There is no overlap of any segments for a member. In cases where a member was eligible for more than one aid category (CDE_AID_CATEGORY) on the same day – the richest aid category has been assigned to the segment.

MassHealth MHEE File and the MA APCD ME File

The MHEE data doesn't replace the ME data. In the event a member is eligible under multiple coverage types, MHEE reflects the richest aid category whereas ME captures multiple coverage types/products in different, overlapping records/segments. The ME file also contains additional data elements not found on the MHEE file.

Additional Information

Member ID

The MassHealth member ID is provided to CHIA. It is consistent with the MassHealth member ID included in MassHealth claims and ME data. It also matches the ID that the MassHealth Managed Care Entities (e.g., MCOs, SCOs, One Care plans) are instructed to populate in their own ME data under the "MassHealth ID" field (that is, HASHNEWMMISID) This enables the data from the MCEs to be linked to the MHEE data.

Note however that the MassHealth ID numbers have been masked. See the field cross reference table below.

TABLE 8.MA APCD ELEMENT CROSS REFERENCES FOR MHEE MEMBER LINKAGE:

File Type	Element Cross Reference	Data Element
MHEE	HASHCARRIERSPECIFICUNIQUEMEMBERID	
MHEE	HASHNEWMMISID	
ME	HASHCARRIERSPECIFICUNIQUEMEMBERID	(ME107)
ME	HASHNEWMMISID	(ME075)
MC	HASHCARRIERSPECIFICUNI QUEMEMBERIDCLEANED	(MC137)
PC	HASHCARRIERSPECIFICUNIQUEMEMBERIDCLEANED	(PC107)
DC	HASHCARRIERSPECIFICUNIQUEMEMBERIDCLEANED	(DC056)

Provider Data

There are four provider ID fields included in the MHEE data which link to the MA APCD Provider (PV) data. To avoid duplication, the Provider Delegate field in the PV data (Derived PV9 - LINKINGPROVIDERDELEGATE) should be restricted to "Y" when joining to the PV data to obtain entity names and other provider attributes.

The provider ID fields in the following table link to the LINKINGPROVIDERID on the Provider file (PV reference: Plan Provider ID, PV002 and Provider Delegate, Derived PV9) where the ORGID equals 3156 (MassHealth PV submissions).

TABLE 9.THE FOUR PROVIDER ID FIELDS:

Provider ID Type	Definition	Provider ID
MCO	Identifies the MCE for members enrolled in managed care -- MCO, SCO, PACE, and One Care plans.	ID_PROVIDER_LOCATION_MCO_LINKAGE_ID
PCC	Identifies a member's PCC, for members in the PCC Plan.	ID_PROVIDER_LOCATION_PCC_LINKAGE_ID
BH	Identifies the behavioral health MCE provider -- currently always MBHP.	ID_PROVIDER_LOCATION_BH_LINKAGE_ID
LTC	Identifies members Nursing or other Long-term care facility.	ID_PROVIDER_LOCATION_LTC_LINKAGE_ID

Active Record

Data analysis should be restricted to active records (IND_ACTIVE=Y). Inactive records reflect data for member IDs that are no longer active, typically due to a member ID change.

Product

This data does not link to the MA APCD PR data, but the field CDE_PGM_HEALTH identifies the product/coverage type. Note that CDE_PGM_HEALTH_BH and CDE_PGM_HEALTH_MC *do not* reflect

products included in the MA APCD PR data. These two fields are specific to managed care enrollment rather than eligibility for particular products captured in the product data.

Richest Eligibility

As MassHealth members may be eligible for care under multiple categories of assistance, the MHEE file captures the richest eligibility (or all records in all categories of assistance available on a particular day) in the CDE_AID_CATEGORY and CDE_PGM_HEALTH fields. By definition, there are no overlapping intervals of time in this file view. Also note that there are three aid category references on the MHEE file. They are shown in the following table:

TABLE 10. COVERAGE TYPES

Category Type	Definition
DE_AID_CATEGORY	Richest aid category
CDE_AID_CATEGORY_BH	Where applicable, the aid category the member was in that qualified them for MBHP enrollment.
QCDE_AID_CATEGORY_MC	Where applicable, the aid category the member was in that qualified them for MC plan enrollment.

Appendix A. External Code Sources

The External Source Codes are an essential source for the collection and maintenance of the MA APCD data. These sources provide guidance through lookup tables and codes enabling CHIA to properly collect, standardize, and clean the data collected from the payers and providers. In the lookup tables featured in each file type's layout, the data element delineates whether an external source code was used to populate a lookup table.

1. MA APCD: EXTERNAL CODE SOURCES

Type	Organization	URL
Countries	American National Standards Institute 25 West 43rd Street, 4th Floor New York, NY 10036	http://www.ansi.org/
States and Other Areas of the US	U.S. Postal Service National Information Data Center P.O. Box 2977 Washington, DC 20013	https://www.usps.com/
National Provider Identifiers National Plan & Provider Enumeration System	Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	**https://nppes.cms.hhs.gov/NPPES/**
Provider Specialties Center for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Health Care Provider Taxonomy Washington Publishing Company	The National Uniform Claim Committee c/o American Medical Association 515 North State Street Chicago, IL 60610	http://www.wpc-edi.com/reference/
North American Industry Classification System (NAICS) United States Census Bureau	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov/eos/www/naics/
Language Preference United States Census Bureau	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov/hhes/socdemo/language/about/index.html
International Classification of Diseases 9 & 10 American Medical Association	American Medical Association AMA Plaza 330 N. Wabash Ave. Chicago, IL 60611-5885	http://www.ama-assn.org/
HCPCS, CPTs and Modifiers American Medical Association	American Medical Association AMA Plaza 330 N. Wabash Ave.	http://www.ama-assn.org/

Type	Organization	URL
	Chicago, IL 60611-5885	
Dental Procedure Codes and Identifiers American Dental Association	American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678	http://www.ada.org/
Logical Observation Identifiers Names and Codes Regenstrief Institute	Regenstrief Institute, Inc. 410 West 10th Street, Suite 2000 Indianapolis, IN 46202-3012	http://loinc.org/
National Drug Codes and Names U.S. Food and Drug Administration	U.S. Food and Drug Administration 10903 New Hampshire Avenue Silver Spring, MD 20993	http://www.fda.gov/drugs/informationondrugs/ucm142438.htm
Standard Professional Billing Elements Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Standard Facility Billing Elements National Uniform Billing Committee (NUBC)	National Uniform Billing Committee American Hospital Association One North Franklin Chicago, IL 60606	http://www.nubc.org/
DRGs, APCs and POA Codes Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/
Claim Adjustment Reason Codes Washington Publishing Company	Blue Cross / Blue Shield Association Interplan Teleprocessing Services Division 676 N. St. Clair Street Chicago, IL 60611	http://www.wpc-edi.com/reference/
Race and Ethnicity Codes Centers for Disease Control	Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA	http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

Appendix B. **Linking Across Files** (Coming Soon)

Appendix C. Glossary

Term	Definition
Accident Indicator	A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Adjudication Data	Any data that describes how a claim was processed for payment. Typically information that would go back to the provider of services is used, but could include contract level information as well.
Admitting Diagnosis	This is the diagnosis (of a unique set of diagnoses) that supports a physician's order to admit a patient into an inpatient setting at a facility.
All Payer Claims Database (APCD)	The All Payer Claims Data Base (APCD) is a dataset of members, providers, products and claims from payers that allow for a broad understanding of cost and utilization across institutions and populations.
Ambulatory Payment Classification (APC)	A payment methodology applied to outpatient claims in a facility; defined by Federal Balanced Budget Act for Medicare claims originally.
Ancillary Services	Any service that supports the primary reason for the medical visit. This can be laboratory, X-ray or other services within or outside of the same facility.
APC	See Ambulatory Payment Classification.
APCD	See All Payer Claims Database.
APCD Field Threshold	The percentage of correct data that needs to be submitted for a particular field to ensure that it "passes". See Variance Request.
Applicant	An individual or organization that requests health care data and information in accordance with 957 CMR 5
Attending Provider	A provider that has direct care oversight of the patient. Typically an individual reported on Facility Inpatient Claims.
Billing Provider	A provider entity that sends claims and requests for adjudication to a carrier for payment.
Capitated Encounter Flag	A MA APCD Flag Indicator that reports a line-item as being covered under a capitation arrangement.
Capitated Payment	Capitation is a contractual payment arrangement between provider and payer. It is the 'per member per month' methodology that does not take 'per service' into account during the contract timeframe.
Carrier-Specific Unique Member ID	The number a carrier uses internally to uniquely identify the member.
Carrier-Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.
Center For Health Information and Analysis	An agency of the Commonwealth of Massachusetts responsible for providing reliable information and meaningful analysis for those seeking to improve health care quality, affordability, access, and outcomes. Formerly the Division of Health Care Finance and Policy until November 5, 2012.
Center	See Center for Health Information and Analysis.
CDT Code	See Common Dental Terminology Code.
CHIA	See Center for Health Information and Analysis.
Claim	A request for payment on rendered services to likely members. Claims can be in many formats: see UB04, HIPAA 837, Reimbursement Form, and Direct Data Entry.
Claim Line	An individual service reporting of a claim. See Line Counter.
Claim Line Type	A MA APCD value that reports a claim line status that moderately relates to the final digit (Frequency Code) of the

Term	Definition
	Type of Bill or Place of Service code on a claim. Options are Original, Void, Replacement, Back Out and Amendment.
Claim Status	A MA APCD value that reports how a claim was processed by the reporting carrier. Relates to reimbursement order on claims.
Claims Adjudication	An evaluation process employed by insurance companies and/or their designees to process claims data for payment to providers.
Claims Data	Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to CHIA.
CMS	See Centers for Medicare & Medicaid Services.
COB	See Coordination of Benefits.
COBRA	See Consolidated Omnibus Budget Reconciliation Act.
Coinsurance Amount	Usually defined as a percentage of the claim that the subscriber pays on covered services to the provider after deductibles have been met, per the plan contract.
Common Dental Terminology Code (CDT Code)	A code set developed for dental procedure reporting by the American Dental Association.
Compound Drug Indicator	A MA APCD Flag Indicator that reports if a pharmacy line had to be compounded for the patient due to patient-specific needs (weight, allergies, administration route) or unavailability of the drug in certain measures.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Refers to the COBRA legislation that requires offering continued health care coverage when a qualifying event occurs with the employed family member. Usually only required of large group employers (20+ employees) under a modified payment schedule for same level of coverage.
Coordination of Benefits (COB)	A process that occurs between provider, subscriber(s) of same household, and two or more payers to eliminate multiple primary payments.
Coordination of Benefits/TPL Liability Amount	The amount calculated by a primary payer on a claim as the amount due from a secondary or other payer on the same claim when the primary payer is aware of other payers.
Copayment Amount	Usually defined as a set amount paid by the subscriber to the provider for a given outpatient service, per the plan contract.
Coverage Level Code	A MA APCD value submitted by the carrier that refines a line of eligibility to report the definition and size of covered lives.
Covered Days	The number of inpatient days covered by the plan under the member's eligibility. See Non-covered Days.
Data Element Name	The Submission Guide element name reference if applicable or the description of derived element if created by CHIA.
Date Service Approved (AP Date)	This is the date that the claim line was approved for payment. It can be several days (or weeks) prior to the Paid Date or on the Paid Date, but cannot fall after the Paid Date.
DC File	See Dental Claim File
DDE	See Direct Data Entry
Deductible	Usually defined as an annual set amount paid by the subscriber to the provider prior to the plan applying benefits. Deductibles can be inpatient and/or outpatient as they are payer/plan specific.
Delegated Benefit Administrator	CHIA assigned Org ID for Benefit Administrator. A Delegated Benefit Administrator is an entity that performs a combination of activities related to benefit enrollment, management and premium collection on behalf of a payer.
Denied Claims	Claims and/or Claim Lines that a payer will not process for payment due to non-eligibility or contractual conflicts.

Term	Definition
Dental Claim File (DC File)	A MA APCD File Type for reporting all Paid Dental Claim Lines of a given time period. File accommodates Replacement and Void lines.
Diagnostic Related Group (DRG)	Diagnostic Related Group: A system to classify hospital inpatient admits into a defined set of cases by numeric representation. Payment categories that are used to classify patients for the purpose of reimbursing providers for each case in a given category with a fixed fee regardless of the actual costs incurred.
Disability Indicator Flag	Indicator that a member has a disability. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Disease Management Enrollee Flag	A MA APCD Flag Indicator that reports if a member's chronic illness is managed by plan or vendor of plan.
Dispense as Written Code	Prescription Dispensing Activity Code
DRG	See Diagnostic Related Group
DRG Level	A reporting refinement from the Diagnostic Related Group coding that reports a level of severity of the case.
DRG Version	The version of the Diagnostic Related Group, a numbering system within the application used to allocate claims into the appropriate grouping date. This is mostly an annual process, although other updates are received.
E-Code	See External Injury Code
EFT	See Electronic Funds Transfer
EHS	Executive Office of Health and Human Services
EHS DW	Executive Office of Health and Human Services Data Warehouse
Employer EIN	Employer Identification Number (Federal Tax Identification Number) of the member's employer.
Employment Related Indicator	Service related to Employment Injury. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Encounter Data	Detailed data about individual services provided by a capitated managed care entity.
EOB	See Explanation of Benefits.
EPO	See Exclusive Provider Organization.
EPSDT Indicator	Indicates that Early Periodic Screening, Diagnosis and Treatment (EPSDT) were utilized. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Excluded Expenses	Amount that the plan has determined to be above and beyond plan/benefit limitations for a given patient. Related to non-covered services.
Exclusive Provider Organization (EPO)	A managed care product type that requires each member to have a PCP assignment within a limited network but offers affordable coverage.
Executive Office of Health and Human Services	EHS
Executive Office of Health and Human Services Data Warehouse	EHS DW
External Code Source	External code sources are lists of values generally accepted as a standard set of values for a given element. Example: Revenue Codes as defined by the National Uniform Billing Committee.
External Injury Code (E-Code)	ICD Diagnostic External Injury Code for patients with trauma

Term	Definition
	or accidents. A subsection of the International Classification of Diseases Diagnosis Codes that specifically enumerate various types of accidents and traumas before diagnoses are applied.
Fee for Service	A payment methodology where each service rendered is considered for individual reimbursement.
Former Claim Number	This is a prior claim number originally assigned to the claim by the provider of service. Its use in the MA APCD dataset is usually to aid with versioning of a claim where versioning cannot be applied due to system limitations.
Formulary Code	A MA APCD Flag Indicator that reports a line-item as being listed on a payers list of covered drugs. This reporting helps to understand patient-out-of-pocket expenses.
Fully-Insured	In a fully insured plan, the employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.
GIC	See Group Insurance Commission.
Global Payment	Payments received of a fixed-value for predefined services on members within a predefined time frame.
Global Payment Flag	A MA APCD Flag Indicator that reports a line-item as being paid under a Global Payment arrangement. See Global Payment.
Group Insurance Commission	The Group Insurance Commission (GIC) is an entity charged with overseeing health and tangent benefits of state employees, retirees and dependents.
Grouper	A tool/application that evaluates each claim and determines where the claim falls clinically across a broad spectrum of values (cases). This can be applied to inpatient and outpatient claims based on the grouper used.
Health Care Home	See Patient Centered Medical Home.
Health Care Payer	A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third-Party Administrators, and self-insured plans.
Health Plan Information	Information submitted by Health Care Payers in accordance with 957 CMR 8.
HCQCC	(Massachusetts) Health Care Quality and Cost Council (HCQCC) Established in 2006, HCQCC collected claim-level detail from third party payers. By 2009, HCQCC's responsibilities were transferred to the Division of Health Care Finance and Policy (DHCFP) and then, in 2012, CHIA was created as an independent agency for the collection and analysis of heath care data.
ICD9-CM	See International Classification of Diseases, 9th edition, Clinical Modification.
Individual Relationship Code	Indicator defining the Member/Patient's relationship to the Subscriber.
Insurance Type Code/Product	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.
International Classification of Diseases, 9th Edition, Clinical Modification	Refers to the International Classification of Diseases, 9th Revision Codes, and Clinical Modification (ICD-9-CM) procedure codes.
Last Activity Date	This is the date that a subscriber's or member's eligibility for

Term	Definition
	any given product was last edited.
Line Counter	An enumeration process to define each service on a claim with a unique number. Process follows standard enumeration from other billing forms and formats.
Logical Observation Identifiers, Names and Codes (LOINC)	Lab Codes for Logical Observation Identifiers, Names and Codes. A method for reporting laboratory findings of specimens back to a health care provider / system.
LOINC	See Logical Observation Identifiers, Names and Codes.
LTC	Long Term Care
Major Diagnostic Category (MDC)	The Major Diagnostic Categories (MDC) is a classification system that parses all principal diagnoses into one of 25 categories primarily for use with DRGs and reimbursement activity. Each Category relates to a physical system, disease, or contributing health factor.
Managed Care Organization	A product developed to control costs of care management through various methods such as limited networks, PCP assignment, and case management.
Market Category Code	A MA APCD ME File refinement code that explains what market segment the policy that the subscriber/member has selected falls under.
Masking	Indicates field is masked in the output extract file (masked output that creates the same random value each time for a specific source value).
MassHealth	The Massachusetts Medicaid program.
MC File	See Medical Claim File.
MCE	Manage Care Entity
MCO	See Managed Care Organization.
MDC	See Major Diagnostic Categories.
Medicaid MCO	A Medicaid Managed Care Organizations is a private health insurance that has contracted with the state to supply Managed Care products to a select population.
Medical Claim File (MC File)	A MA APCD File Type for reporting all Paid Medical Claim Lines of a given time period. File accommodates Facility, Professional, Reimbursement Forms and Replacement and Void lines.
Medicare Advantage	A Medicare Advantage Plan (Part C) is a Medicare health plan choice offered by private companies approved by Medicare. The plan will provides all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage and may offer extra coverage such as vision or dental coverage Medicare Benefits (Part A & B)
Medicare Benefits (Part A & B)	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system. Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. Part B helps cover medically-necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.
Member	A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.
Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. See Deductible.
Member Deductible Used	Member deductible amount incurred.
Member Eligibility File	A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics;

Term	Definition
	race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.
Member PCP Effective Date	Begin date for member enrollment with Primary Care Provider (PCP).
Member PCP ID	The member's Primary Care Physician's ID.
Member PCP Termination Date	Member termination date from that Primary Care Provider (PCP).
Member Rating Category	Utilized for Medicaid MCO members only, it defines the Member Medicaid MCO category.
Member Self Pay Amount	The amount that a Patient pays towards the claim/service prior to submission to the carrier or its designee.
Member Suffix / Sequence Number	Numeric suffix appended to the health insurance contract number that identifies the type of family member covered under the contract .
Members SIC Code	A code describing the line of work the enrollee is in. Carriers will use Standard Industrial Classification (SIC) code values.
MMIS	Medicaid Management Information System
NAICS	See North American Industry Classification System.
National Billing Provider ID	National Provider Identification (NPI) of the Billing Provider.
National Council for Prescription Drug Programs (NCPDP)	The Standards Organization for the pharmacy industry.
National Plan ID	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
National Provider Identification (NPI)	A unique identification number for covered health care providers and health plans required under the Health Insurance Portability and Accountability Act (HIPPA) for Administrative Simplification.
National Service Provider ID	National Provider Identification (NPI) of the Servicing Provider.
NCPDP	See National Council for Prescription Drug Programs
Non Covered Days	The number of inpatient days not covered by the plan under the member's eligibility. See Covered Days.
Non-Covered Amount	An amount that refers to services that were not considered covered under the member's eligibility.
North American Industry Classification System (NAICS)	A standard classification system used to define businesses and the tasks within a business for statistical analysis, used by Federal statistical agencies for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy
NPI	See National Provider Identification
Organization Identification (Org ID)	A CHIA contact management unique enumeration assigned to any entity to allow for identification of that entity. This internally generated ID is used by CHIA to identify everything from carriers to hospitals in addition to other sites of service.
OrgID	See Organization Identification
P4P	See Pay for Performance
Paid Date	The date that a claim line is actually paid. Date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment. This can be the same date as Processed Date.
Patient	An individual that is receiving direct clinical care or oversight of self-care.
Patient Centered Medical Home (PCMH)	An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when

Term	Definition
	appropriate, the patient's family
Patient Control Number	This is a unique identifier assigned by the provider for individual encounters of care or claims.
Payer	See Health Care Payer
Payer Claim Control Number	A unique identifier within the payer's system that applies to the entire claim for the life of that claim. Not to be confused with Patient Control Number that originates at the provider site.
Payment	Financial transfer from payer to provider for services rendered to patients, quality maintenance, performance measures or training initiatives.
PBM	See Pharmacy Benefit Manager.
PC File	See Pharmacy Claim File.
PCMH	See Patient Centered Medical Home.
PCP	See Primary Care Physician.
PCP Indicator	A MA APCD Flag Indicator that reports a claim line-item as being performed by the patient's Primary Care Physician. See Primary Care Physician.
Pharmacy Benefit Manager (PBM)	A Pharmacy benefit manager (PBM) is a company that administers all or some portion of a drug benefit program of an employer group or health plan.
Pharmacy Claim File (PC File)	A MA APCD File Type for reporting all Paid Pharmacy Claim Lines of a given time period. File accommodates Replacement and Void lines.
Plan Rendering Provider Identifier	Carrier's unique code which identifies for the carrier who or which individual provider cared for the patient for the claim line in question.
Plan Specific Contract Number	Plan assigned contract number. This should be the contract or certificate number for the subscriber and all of his/her dependents.
PMPM	Per Member Per Month
Point of Service (POS)	A point-of-service (POS) plan is a health maintenance organization (HMO) and a preferred provider organization (PPO) hybrid. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.
POS	See Point of Service
PR File	See Product File
Preferred Provider Organization (PPO)	A plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
PCC	Primary Care Clinician
Primary Care Physician (PCP)	A physician who serves as a member's primary contact for health care. The primary care physician provides basic medical services, coordinates and, if required, authorizes referrals to specialists and hospitals.
Primary Insurance Indicator	A MA APCD Flag Indicator that reports if the payer adjudicated a Claim Line as the Primary Payer.
Private Health Care Payer	A carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter

Term	Definition
	176F, a self-insured plan to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.
Product	Any offering for sale by a health plan or vendor. It typically describes carrier-based business models such as HMO, PPO but is also synonymous with processing services, network leasing, re-pricing vendors.
Product Enrollment End Date	The date the member dis-enrolled in the product.
Product Enrollment Start Date	The date the member enrolled in the product .
Product File (PR File)	A MA APCD file that reports all products that a carrier maintains as a saleable service. Typically these products are listed with the Division of Insurance.
Product Identifier	A unique identifier created by the submitter to each Product offered. It is used to link eligibilities to products and to validate claim adjudication per the product.
Provider	A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider, as defined by CHIA	A Provider is an entity or person associated with either: 1. Providing services to patients, and/or 2. Submitting claims for services on behalf of a servicing provider, and/or 3. Providing business services or contracting arrangements for a servicing provider. A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider File (PV File)	A MA APCD file containing information on all types of health care provider entities. Typically these are active, contracted providers.
Provider ID	A unique identifier assigned by the carrier or designee and reported in the MA APCD files.
Public Health Care Payer	The Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the Commonwealth Care Health Insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the Group Insurance Commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B. Also includes Medicare.
PUF	Public Use File
PV File	See Provider File
QA	See Quality Assurance
Quality Assurance (QA)	The process of verifying the reliability and accuracy of data within the thresholds set and rationales reported.
Rebate Indicator	A MA APCD Flag Indicator that reports if a pharmacy line was open for any rebate activity.
Referral Indicator	A MA APCD Flag Indicator that reports if a claim line required a referral regardless of its final adjudication.
Reimbursement Form	A form created by a carrier for subscribers/members to submit incurred costs to the carrier that are reimbursable under the benefit plan.
Risk Type	Refers to whether a product was fully-insured or self-insured.
Route of Administration	Indicates how drug is administered. Orally, injection, etc.
Script number	The unique enumerated identifier that appears on a

Term	Definition
	prescription form from a provider.
Self-Insured	A plan offered by employers who directly assume the major/full cost of health insurance for their employees. They may bear the entire risk, or insure against large claims by purchasing stop-loss coverage. The self-insured employers may contract with insurance carriers or third party administrators for claims processing and other administrative services; others are self-administered.
Service Provider Entity Type Qualifier	A MA APCD identifier used to refine a provider reporting into one of two categories, a person, or one of several non-person entity types.
Service Provider Specialty	The specialty of the servicing provider with whom a patient sought care.
Service Rendering Provider	The health care professional that performed the procedure or provided direct patient oversight.
Severity Level	See DRG Level
Single/Multiple Source Indicator	Drug Source Indicator. An identifier used to report pharmacy product streams.
Site of Service - on NSF/CMS 1500 Claims	Place of Service Code as used on Professional Claims. This is a two-digit code that reports where services were rendered by a health care professional.
Special Coverage	A MA APCD identifier used to refine eligibility with non-traditional coverage models to explain covered services and networks for this population. Valid choices are Commonwealth Care, Health Safety Net or N/A if not applicable.
Submission Guide	The document that defines the required data file format, record specifications, data elements, definitions, code tables and edit specifications.
Submitter	Any entity that has been registered with CHIA as a data submitter. This can be health plans, TPAs, PBMs, DBAs, or any entity approved to submit data on behalf of another entity; requires registration with CHIA. See *Organization ID, above*.
Subscriber	The subscriber is the insurance policy holder. The individual that has opted into and pays a premium for health insurance benefits under a defined policy. In some instances, the subscriber can be the Employer, or a non-related individual in cases of personal injury.
Third-Party Administrator (TPA)	Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.
Third-Party Liability (TPL)	Refers to the coverage provided by a specific carrier for certain risks; typically work, auto, personal injury related.
Threshold Reduction	A process of the MA APCD Variance Request that a submitter performs to reduce the percentage of quality data that they must submit. This is performed prior to submitting a file to insure that A-Level Thresholds are met to pass the file into Quality Assurance.
TPA	See Third-Party Administrator.
TPL	See Third-Party Liability.
Type of Bill - on Facility Claims	This is a two-digit code that reports the type of facility in which services were rendered.
UB04	See Universal Billing Form 04.
Unemployed	An individual that does not hold a paying position with a company.

Term	Definition
Universal Billing Form 04	A standard billing form created by the National Universal Billing Committee for Facility Claims. The 04 refers to the last updated version of the claim format. It is typically a paper form but electronic versions of it exist.
Variance	See Variance Request
Variance Request (VR)	A request to CHIA that explains why an organization cannot submit a field (or fields), meet a threshold (or thresholds), or submit a file (or files). This is a form, developed by the MA APCD, which defines base reporting percentages for all data elements on all filing types, where the submitter may disclose reasons for not meeting base-percentage reporting, and request a threshold reduction to percentages that can be met.
Version Number	Version number of this claim service line. An enumeration process required by the MA APCD Claims Files to insure that the most recent line(s) of any given claim are used in that claims analysis at time of reporting.
Voided Claims	Claim lines filed that will be excluded from analysis (i.e. Claims that were deemed not eligible for submittal).

CONTACT INFORMATION

Please contact CHIA with questions regarding the content and use of the data.

Address:

The Center for Health Information and Analysis
501 Boylston Street, 5th floor
Boston, MA 02116

General APCD questions should be sent to the APCD mailbox:

CHIA-APCD@state.ma.us

Please direct questions regarding data requests/applications to the APCD data application mailbox:

apcd.data@state.ma.us